

July 26, 2016
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To Members of the Medicaid Provider Audit Workgroup,

We attended the public hearing on July 11, 2016 held in Indianapolis. We are writing to support all comments submitted by the dental providers, the Attorney representing several dental providers, and Mr. David Jose. We support the committee's review of the following points made at the hearing:

- Audit results should give consideration for underpayment as well as overpayment.
- Providers receive a request for production of specific documents (e.g. policies, meeting minutes) but there is no description of what OMPP is actually seeking. If OMPP clearly indicates what it is looking for, the provider could send appropriate documentation.
- Auditors should have a background in the specialty they are auditing and/or have access to consultation with a specialty provider to ensure an understanding of the common practices of documentation within that field.
- Payback procedures should give financial incentives for demonstration of improvement by the provider moving forward. (i.e. payback amounts reduced or eliminated if identified technical errors are satisfactorily corrected with an agreed upon timeframe.)
- The confidence level reporting by OMPP for initial audit findings does not seem to reflect the actual error found in the claims sampling in final audit findings.
- Payback amounts should not be calculated to be beyond the actual payment received for all completed services for a specific code set.
- The lookback period should allow for consideration of the advancement in technology in electronic record keeping of providers, especially when these providers are participating in Medicaid's incentives for EMR adoption.

Additionally, we offer the following additional consideration:

Many provider organizations make substantial investments in personnel and organizational structure for internal corporate compliance programs which are designed to prevent, reduce and if necessary correct any inaccurate, or erroneous claims or documentation necessary to support the claim. Additionally, we establish internal surveillance practices to identify any individual providers who may be inaccurately documenting their service delivery. This is a costly administrative burden that providers implement to ensure Medicaid Members service claims are submitted accurately and with the necessary supporting documentation. However, no consideration to this activity is given by OMPP in the audit processes or in the calculation of extrapolation of payback.

Under the current extrapolation methodology, providers who invest in this level of activity to ensure the cleanest possible claims and service documentation receive no different audit payback methodology than a provider who blatantly and fraudulently submits claims to Medicaid when they provided no service at all. While, criminal prosecution considerations and program exclusion penalties may give consideration for the presence of these programs, the investment in these programs goes far beyond avoiding criminal activity among the organization's providers and demonstrates an active attempt by the provider to ensure compliance with Medicaid's billing and service documentation requirements.

We believe that providers who implement an active corporate compliance program with internal surveillance or auditing and who demonstrate corrections in the form of refunds and/or documentation that demonstrates corrective actions internally should have an adjustment to the extrapolation formula which gives favorable consideration to these actions.

The stated 95% confidence levels for the initial audit findings appears extremely inaccurate when compared to final audit findings that demonstrate an extremely lower confidence level. This discrepancy weakens the audit process and only serves to lengthen the process, create continued administrative burden and cost and lengthen the appeal process, thus incurring additional legal expense and interest.

Thank you for considering these comments.

July 12, 2016

The Indiana Association for Home and Hospice Care (IAHHC) is the trade association that represents the home care industry. IAHHC represents home health agencies, hospice agencies and standalone personal service agencies that provide nonmedical care. Home health and hospice agencies serve Medicaid members enrolled in Traditional Medicaid and Medicaid managed care programs (Hoosier Healthwise, Hoosier Care Connect and HIP). Personal service agencies may be Medicaid enrolled waiver providers and serve Medicaid members under Traditional Medicaid.

Senate Enrolled Act 364 established a Provider Work Group to "discuss the policies and procedures used in the performance of Medicaid provider audits and possible improvements to the audit process". This letter provides our public comments about Medicaid provider audits.

IAHHC recognizes the importance of preserving the integrity of the Medicaid program and that FSSA is required by the Centers for Medicaid and Medicaid Services (CMS) and their own rules to perform program integrity audits. However, there are concerns that we have with the current audit process.

First Concern: FSSA Auditors are not Subject Matter Experts

One concern is that individuals performing Medicaid provider audits are not subject matter experts (SMEs). This means that auditors do not understand the service delivery and documentation standards by provider type and specialty for home health, hospice and home and community based waiver providers. In the past, this has resulted in providers having to point out the Medicaid program requirements to auditors by referring auditors to the appropriate sections of the OMPP Medical Policy Manual and provider specific modules.

At this time, FSSA will be requiring the MCEs to broaden their scope of provider audits. The MCEs have not demonstrated an understanding of home health and hospice during the implementation of Hoosier Care Connect and HIP 2.0. This has been reflected in that some of the MCEs did not meet readiness standards in configuring their claims operating system to pay home health and hospice claims correctly. IAHHC has been trying for years to have OMPP and the MCEs advise home health providers how they must bill for 60 days of care or more for home health services under HIP. The HIP Reimbursement Module specifies that for 60 days of care or more, the MCE pays the Medicare rate. We are still waiting for a response on what the "Medicare" rate is and what codes providers should use to bill. This question/issues has been raised multiple times with OMPP and its contractors. If as a trade association IAHHC cannot get a response to this question, then how can home health providers not have concerns about provider audits. Home health, hospice and PSAs should not have to be the entities educating FSSA staff or contractors regarding scope of service, documentation standards and claims billing. FSSA as an oversight agency and FSSA contractors should have a solid understanding of all these areas.

Look Back Period

Providers are required to keep documentation for seven years from the date of service. While Medicaid has a look back period of 7 years, Medicaid provider audits could be limited to 23 years from the dates of service. This timeframe is sufficient to address utilization issues and recoupment while not impacting a provider for repayments that go as far back as 7 years. An audit that encompasses recoupment of 7 years of overpayment is devastating to a small business. Home health, hospice and PSAs are predominantly small businesses. IAHHC recommends that FSSA consider limiting the look back period to 2-3 years.

Official Responses from FSSA

IAHHC has requested clarification via the FSSA Intranet Quorum on several benefits and coverage issues. Some of these questions have been waiting for a response now for more than one year. There are several outstanding home health and hospice issues awaiting a response from OMPP Medical Policy and OMPP Medical Policy Consideration. If OMPP cannot respond to clarification on their policies, this raises concerns about how accurate the provider audits will be when referring to these policies as the basis of their audits.

Please do not hesitate to reach out to me, Michelle SteinOrdóñez, Membership Services Director or Jean Macdonald, Home Health Policy Director if we can be of further assistance. You may contact me at evan@iahhc.org, Michelle at michelle@iahhc.org and Jean at jean@iahhc.org.

Thank you for the opportunity to provide public comments.

Sincerely,

Evan Reinhardt, MBA

Executive Director

Indiana Association for Home and Hospice Care

Cc: Michelle SteinOrdóñez

Jean Macdonald

Hello,

I attended the public hearing today and found it very informative. I have a couple of issues I would like to present but am not a fan of public speaking. Below are some issues that we are seeing in Medicaid audits for some of our clients.

Clients are getting dinged for No Signature even though the Medicaid manual says to obtain the patient signature, if you are unable to obtain the signature you "SHOULD" document a reason why. Should is a suggestion. Manual/Law needs to be more specific

Medicaid manual says PCR/ runsheet needs to have the RID # documented. However, that is a very hard task to complete seeing that a lot of the 911 calls are being provided to patients that don't have medicaid until after the transport and medicaid retros back. You expect the Medics to check eligibility and go back into the run and add it.

Medicaid/Mdwise go by the state's definition of Emergent, which quotes the "prudent Layperson". Explain to me how a Physician is a prudent layperson for Mdwise to be auditing claims. The physician has more knowledge and could look further into medical conditions that could/couldn't be happening. Auditors should be more well versed in the field that are auditing.

Clients are often getting dinged on an audit for patient name on the runsheet not matching on the medicaid system. However, sometimes patients get married and it changes over time. If Medicaid changes the name, you expect the name to be changed from years ago? We even had runs with the Name John or Andy getting hit for not saying Jonathan or Andrew. Give me a break it's the same thing.

Lastly, the destination and pickup complete info. Our clients claims are getting dinged for the full pickup address and destination address being on every run. Including number, name, city, state, zip and county. Just because the county isnt listed its wrong??? That just absurd.

I feel like the Medicaid Guidelines need to be re written and worded and remove and gray area. And be more lenient towards emergent medical transports

Thanks,

Brandon Driscoll
Office Manager

August 1, 2016

To: Tatum Miller, Provider Relations Director, Indiana FSSA

From: Brian Tabor, IHA Executive Vice President

Re: Medicaid Provider Audit Work Group created by SEA 364

On behalf of the 170-plus member facilities of the Indiana Hospital Association (IHA), we appreciate the opportunity to provide input to the Medicaid provider audit work group created by SEA 364. We thank the authors and sponsors for developing this legislation, and commend the Office of Medicaid Policy and Planning (OMPP) for holding field hearings on audit performance and possible process improvements. IHA has solicited feedback from our members, and the items below represent the priorities we have identified. We hope that you will consider these policies, and please let us know if there is more background information that we can provide in support of these recommendations.

☐ Indiana should establish a limited lookback period for Medicaid integrity programs. When it comes to Surveillance and Utilization Review Section (SURS) audits, there is currently no limit on the number of prior years that can be audited. In practice, the State's audit contractors have limited their scope to the previous seven years of Medicaid claims, based on the statutory requirement for providers in Indiana to maintain medical records under IC 16-39-7-1(b). However, there is no true restriction in Indiana statute or regulation regarding how far back claims can be audited.

Seven years is an exceedingly long time, especially when compared to the three-year lookback period for Medicare and Medicaid Recovery Audit Program (RAC) programs. Even further, by the time some SURS audits are completed, some claims identified in the sample at the outset of the audit were less than seven years old, but have passed the seven-year timeframe by the time the claim is deemed by the SURS unit to be an overpayment.

Additionally, the Centers for Medicare and Medicaid Services (CMS) recently issued final rulemaking establishing that a provider must report and return an overpayment that is less than six years old from the date payment was received (81 Fed. Reg. 7654, February 12, 2016). While this rulemaking only applies to Medicare Parts A and B, it seems plausible that any future Medicaid rulemaking will be generally consistent with this policy.

It must be noted that audit findings are often not related to provider error. The last four hospital-related SURS audits conducted here in Indiana identified overpayments that were due to processing errors by the State's Medicaid system. When audit contractors identify such errors going back seven years or more, this can create significant problems for hospitals' finances. The negative impacts are compounded for safety net hospitals, who lose the opportunity to recover Medicaid payment shortfalls for prior years through programs like Disproportionate Share Hospital (DSH) payments. We ask that you limit the lookback period for Medicaid processing errors to the previous two years. This would properly incentivize the State to work with its claims processing vendor to ensure it is complying with current Medicaid policy. In cases where the provider is in error, the lookback period should be no more than six years, better conforming with current Medicare policy.

Indiana should, whenever possible, align with Medicare Recovery Audit Contractor (RAC) program standards. Creating more consistency between federal and state programs will save resources and eliminate confusion for providers. The Medicare RAC has made several improvements within the last six months to address the burdens this program can create. In addition to the previously mentioned three-year lookback period, CMS has required all federal RAC contractors to enhance provider portals and set new record request limits. CMS has also mandated a 30-day discussion period (similar to the "informal consultation" required in the introduced version of SEA 364) and a 30-day hold before recoupment/adjustment. Our request is to work with OMPP to apply these updates to Indiana's Medicaid RAC program.

Lastly, we would ask for audit transparency, especially if extrapolation is used in auditing. Currently, information is not provided to explain the state SURS unit audit process. It is essential that any methodology be published and ready available so that providers understand the sampling and extrapolation. At the federal level, Medicare RAC and Medicare Administrative Contractor audit samples follow RAT-STATS, published by the Office of Inspector General of the U.S. Department of Health & Human Services.

IHA fully supports the State's efforts to prevent waste, fraud, and abuse in the Medicaid program. Hospitals also take seriously their responsibility to ensure accuracy in billing and identify improper payments. However, there are unreasonable burdens that can be placed upon providers as part of program integrity audits. By implementing shorter lookback periods as outlined above, aligning the Medicaid RAC program with current Medicare policy, and ensuring transparency in any extrapolation, Indiana's program integrity efforts will be more efficient and provide better results for taxpayers and providers.

cc: Sen. Eric Bassler, Sen. Patricia Miller, Rep. Ronald Bacon, Rep. Dennis Zent, Rep. Cindy Kirchhofer, Rep. B Patrick Bauer, Dr. John Wernert, Joe Moser, Shane Hachett, Jim Waddick, Gus Habig